

Section 2

Gaining and Maintaining Control of Your Health Insurance

This section is concerned with obtaining and then effectively managing and using your health care coverage and provider relationships. It will help you choose wisely and be a savvy consumer once you have coverage, to get the most out of what you have. It can also help you decide if what you have is right for you.

Tips: Checking out a plan

Make certain that the coverage you buy fits your needs, and that you receive the best price for the coverage. Your investigation should never be based on rates alone. Be sure to compare benefits as well. Look at two or three different plans, and be sure to compare them against your needs as well as to one another.

Benefits: Be sure you understand the benefits as they are listed. Look at what will **not** be covered by the contract, not just what will be.

Limitations and exclusions: Find out if there are special requirements for obtaining benefits. Example: Do you need prior authorization for some services, and how do you obtain that authorization? Are there waiting periods before coverage goes into effect?

Claims: Before you buy, make sure you understand how to file a claim, where to send it, and how you will collect.

Costs: Premiums for health insurance will vary greatly because there are no standard plans. When you look at bids from several companies, you will also need to look carefully at the benefits offered.



Tips: Checking out an agent

- ✓ **Many people buy health insurance** from agents who may represent only one or a number of licensed companies. Others may buy directly from companies themselves. Some companies sell their policies by mail; others may have offices that insurance purchasers can visit.
- ✓ **Agents earn a commission on your business** and should do more than just sell you a policy. They should answer your questions. Do not hesitate to ask your agent about your insurance problems.
- ✓ **If you need additional information**, contact the company that provides your coverage. You are the customer, and they should respond to you.
- ✓ **Never deal with an unlicensed agent.** Ask to see his or her license. Companies also must be licensed. You can check on any company or insurance representative's licensed status by calling the Office of the Insurance Commissioner toll-free at **1-800-562-6900**.
- ✓ **Never let yourself be pressured** by any insurance sales representative. You have the right to look at any policy before you buy it. Never buy because of a threat that "this coverage won't be available tomorrow." Report any inappropriate behavior to the Insurance Commissioner's investigators at **www.insurance.wa.gov** or call **1-800-562-6900**.
- ✓ **Never buy an insurance policy you do not understand.** Ask to see the benefits explained in writing — in simple terms. Be sure to keep that piece of paper with the policy after you buy it.
- ✓ **If you speak a language that the insurance agent cannot understand**, make sure that you arrange for an adult translator to accompany you.
- ✓ **Never give any insurance representative money** or a check without getting a receipt.

Tips: Checking out a company

Before you buy health coverage, find out about the company selling the plan. Here are key factors to consider:

Customer Service. Find out how the company services its policyholders. Does the company have a toll-free customer service number?

Complaint History. Has the company had an unusually high number of consumer complaints? Check with our Consumer Hot Line at **1-800-562-6900**.

Licensing Status. Make sure the insurance company is licensed to do business in Washington state. Call our Consumer Hot Line to check a company's status at **1-800-562-6900**.

Financial Stability. Financial stability helps ensure that a company can pay its claims. In addition, Washington state law establishes requirements that each company must follow, and insurers are continually monitored by the Office of the Insurance Commissioner to make sure they are financially stable. Independent organizations also rate the financial stability of insurance companies. Your public library may have published ratings from these sources. However, if the carrier is approved to do business in Washington state, that alone is greater assurance than any accreditation.



Questions to ask:

- **What type of plan are you purchasing?** (i.e. state sponsored, group, self funded, individual, association)
- **What does the plan pay for and what does it exclude?** Look in particular for preventive care, immunizations, well-baby care, substance abuse, organ transplants, durable medical equipment, alternative or chiropractic care.
- **Does the plan have mental health benefits?**
- **Will the plan pay for long-term physical therapy?**
- **How much do you have to pay** when you receive health care services, or how much is the co-payment or deductible? How often do you have to pay the co-payment or deductible (per year, per occurrence?)
- **Are there limits on how much you must pay** for health care services you receive (out-of-pocket maximums)? Are there maximums per year, per occurrence?
- **Are there limits on the number of times** you may receive a service (lifetime maximums, daily or annual benefit caps)?
- **Has the company** had an unusually high number of consumer complaints?
- **What happens when you call** the company's consumer complaint number?
- **How long does it take to reach a real person?**
- **Will the plan pay for prescriptions?**
- **Is your favorite doctor** or other health care professional part of the carrier's network?
- **Will you be able to choose your Primary Care Provider (PCP)?** If you don't like her or him, what recourse will you have?
- **How will you get access to specialists?**
- **What do the carriers consider** to be urgent and emergency care?
- **What treatments are considered “experimental”** and therefore not covered?
- **Does the plan have a “non-duplication of benefits” clause?** If not, how does it coordinate benefits with other plans?
- **What options will you have** if you disagree with the treatment plan?

Getting off to a good start with your health care provider

Decide what kind of relationship you want. Are you the type of person who wants to actively manage your own care, or would you rather “leave it to the experts?” Be clear with your practitioner about what you expect.

Choose your Primary Care Provider (PCP) carefully. All managed care plans require you to designate a PCP from the providers in their network. Ask your carrier for a list of PCPs who are accepting new patients, and tell your carrier you want information about the providers, including:

- **Education and certification**
- **Professional experience**
- **Any disciplinary actions** that may have been taken against them by a professional association or government licensing agency
- **A history of complaints** or grievances with the carrier
- **Philosophy of medicine and care**
(If available, this may be one of the best tools you have in making your choice.)

Ask your friends, acquaintances or co-workers for recommendations or experiences with particular providers. These may be more telling than the provider’s medical training or professional background.

If your plan allows for complementary and alternative providers to serve as PCPs, you might consider whether their approach is preferable for you.

Plan your health care. Some plans and providers offer booklets, books, classes or online information to help you stay healthy or manage an illness. Be sure to ask what assistance is available.

Schedule a routine check-up once you’ve chosen your PCP.

Before your appointment, write down information about your problem or illness and your questions, so you won’t forget to tell your PCP what’s important. Past health history may also be important.

If you feel you cannot be frank with your provider, you may have chosen the wrong person and might consider another choice. You should be able to communicate what you expect, and any information relevant to your condition or problems.

Take the time to read and understand your plan’s grievance procedures. Some people are afraid they’ll be labeled a “complainer” for disagreeing with the doctor or insurance company. Remember, you are entitled to the services in your contract. Don’t be afraid to fight for them if you feel you’ve been treated unfairly.

During the appointment, be sure you understand what tests, treatment and follow-up will be used. Ask how you will get the results of the tests or the recommended treatment.

If tests have come back negative or inconclusive, ask about further tests or treatment. You may wish to do this even if the problem has disappeared, especially if it was severe.

You may reject any treatment that your PCP recommends, or question the basis for his or her opinion. It's your body and your insurance. Health care providers are your advisors, not your superiors. You may want to ask your provider for a second opinion.

If your problem persists, don't hesitate to call your provider.

Complementary and Alternative Providers

Washington state law requires state-regulated insurers to cover services provided by all of the state's licensed categories of health care providers including, but not limited to, chiropractors, medical doctors, acupuncturists, naturopaths, physicians assistants, registered nurses, podiatrists, nurse midwives and massage therapists.

Many managed care plans require "gatekeeper" visits before you can be referred to another provider, and this applies to all types of providers, including alternative providers. Most managed care plans restrict enrollees to providers in their own network.

Carriers are obligated to provide adequate networks containing every category of provider so that you have the full range of options the law requires. Also, the condition must be covered by your policy and its treatment must fall into the particular provider's scope of practice.

This law applies to all state-regulated plans. It does not apply to self-funded employer plans or union trusts, which are exempt from state regulation under federal law.

Women's Direct Access

Washington state law requires state-regulated health-insurance carriers to cover direct access to women's health-care service providers when that care is appropriate. The law requires health insurers to give women direct access to specific providers of women's health-care services within the carrier's network without being forced to visit a so-called "gatekeeper" or PCP first. Many women prefer to see an OB/GYN, nurse practitioner or certified nurse midwife, and by law do not have to see a family practitioner for permission first.

Health insurers must ensure that female patients have direct access to timely and appropriate women's health care services and are allowed to choose from an adequate network of women's health-care practitioners. The law applies to all state-regulated plans. It does not apply to self-funded employer plans or union trusts, which are exempt from state regulation under federal law.

Filing Claims

Things to do before you file a claim:

- **Review your policy** or employee booklet carefully to be sure the service in question is covered. If you have any reason to think that a health-care service may not be covered, or that your carrier may not agree with your interpretation of the policy, talk it over first with your provider and with the insurance carrier. Resolving questions first can prevent complications later on.
- **Most managed care systems** only require you to make a co-payment, so you may not have to handle any significant paperwork for a covered service. But don't assume a treatment or service is covered. Follow your plan's rules, including pre-certification requirements and use of network providers.
- **Fill out any claim forms** the provider or carrier gives you, including your policy number and other identifying information.

How to submit a claim yourself:

- **Find out if your provider submits** the claim for you or if you need to do it.
- **If you need to do it**, review the information to be sure it is complete and correct.
- **File the claim** as soon as you get the bill from the provider.
- **Send it** to the correct address.
- **Keep a copy** for your reference.
- **Wait for your carrier's statement** before you pay your provider directly.
- **Allow reasonable time** for the company to process your claim. The company must inform you if it needs any additional information to complete the claim. Sometimes, it will request additional information directly from the providers, in other cases, it will return the claim form to you to get more information.
- **If the carrier denies your claim**, it must send you an explanation of benefits that explains its decision.

If your claim is denied:

- **The reason for denial** should be stated on your explanation of benefits.
- **If you disagree with the basis stated for denial**, check your policy or employee booklet for the company's appeal procedures.
- **The company should be able to answer** procedural questions about appeals over the phone. Call the carrier's assistance line (the telephone number should be listed on your statement).
- **Your appeal should be in writing** and may require information from your doctor.
- **Remember that you may be responsible for co-pays** on some services and/or prescriptions.

Getting Help

You have rights as a health insurance consumer, and should understand what they are and how to exercise them.

Patient Bill of Rights

The Patient Bill of Rights was passed by the Washington State Legislature in 2000 to ensure that patients covered by health plans receive quality care designed to maintain and improve their health, including sufficient and timely access, and adequate choice of health-care providers. It outlines procedures to ensure that patients:

- **Are assured that health-care decisions** are made based on appropriate medical standards;
- **Have better access** to information regarding their health insurance plans;
- **Have access to a quick and impartial process** for appealing denials of coverage;
- **Have the right** to independent third-party reviews of denials;
- **Are protected** from unneeded invasions of their privacy, and;
- **Can seek redress for damages** that result when managed care insurers withhold or deny appropriate care.

These provisions took effect on July 1, 2001, or on the date of the insurance policy's renewal.

• Privacy guarantees

A health carrier is prohibited from releasing personally identifiable health information unless it is authorized in writing, unless it is required to control sexually transmitted diseases, or unless it is covered by existing privacy laws applying to health information. The Insurance Commissioner adopted rules to implement these requirements on Jan. 9, 2001. These rules took effect on July 1, 2001 with benefits effective on the policy renewal date.

For additional help with health insurance issues, you can consult with a volunteer counselor from the Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine. SHIBA HelpLine is a statewide network of trained volunteers who educate, assist, and advocate for consumers regarding health insurance and health care access. Volunteer counselors are impartial and highly trained by the Insurance Commissioner's office, and the service is free. To be referred locally, call **1-800-397-4422**.

- Disclosure of health plan benefits and exclusions

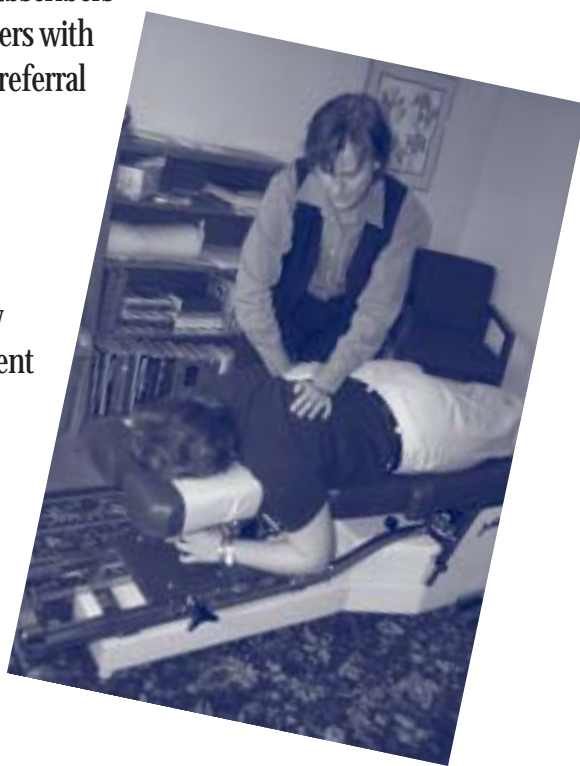
A listing of covered benefits, including prescription drug coverage, must be disclosed prior to purchase of any health plan. This disclosure must include any exclusion, limitation or reduction in coverage, as well as any coverage criteria which may be applied when determining what is a covered service. Other items to be disclosed prior to purchase are the carrier's policies to protect confidentiality, premium, and other enrollee costs, a summary of grievance procedures, an explanation of the amount you need to pay for services (i.e. copays, deductibles or co-insurance) and a convenient means of obtaining a list of participating providers. Additional information describing the plan and its operations must be made available upon the request of a prospective enrollee or a current enrollee.

- Access to providers

Health carriers must allow subscribers to choose a primary health care provider from a list of participating providers and allow them to change providers. Carriers must provide prompt and appropriate referrals to specialists. When chiropractic care is covered, subscribers must be allowed direct access to chiropractic care. Subscribers with complex or serious conditions may even receive a standing referral to a specialist.

- Redress for damages

Health carriers and their employees and agents must follow accepted standards of care when making health care treatment decisions. In the event that they fail to follow accepted standards of care, they are liable for damages for harm caused to the consumer. Consumers must exercise the opportunity for independent review prior to suing their carrier, unless they have already been hurt or an independent review is deemed not beneficial to the enrollee.



- Grievance procedures

Each health carrier must implement a grievance process under which an enrollee can appeal any denial of coverage. The process must meet standards established by the Insurance Commissioner, as well as requirements regarding timelines, notice and due process established in the law. The process must be prompt, fair and impartial, providing timely notice of its results to the enrollee. Notice of other options for alternative treatment, further appeal or independent third-party review must be provided.

• Independent third-party review of appeals

An enrollee whose request for a service or benefit has been denied may seek an independent third-party review, and insurers must develop a process to allow it. The results of this review are binding on the carrier.

• Other appeals

- ◆ **Employer Plans:** If your plan is a “self-funded” benefit offered by an employer, or by a bona fide union trust under a union contract, the state is prohibited under federal law from jurisdiction. Instead, you may file a complaint with the U.S. Department of Labor (DOL) Employee Benefits Security Administration (1-866-275-7922). The DOL does not interpret provisions of any particular health plan or require employers to pay claims, but may investigate your complaint. In some disputes, the DOL may suggest personal legal advice as your best option.
- ◆ **Government/Church Plans:** If the plan is self-funded, but offered through a government or church employer, follow the appeals procedures outlined in your benefit booklet and other plan documents. In most cases, ultimate responsibility for resolving these disputes rests with the governing body of the employer sponsoring the plan, such as a school board.
- ◆ **The disabled:** If you have a disability, you may have special protections available under the Americans with Disabilities Act (ADA) that apply specifically to self-funded coverage. You can reach the ADA Technical Assistance Center at 1-800-949-4232 or the U.S. Department of Justice at 1-800-514-0301 (voice) or 1-800-514-0383 (TDD).



Filing a Complaint with the Commissioner

If you've tried unsuccessfully to resolve a claim problem with your company or agent and still believe you have a valid case, contact the Office of the Insurance Commissioner's Consumer Hot Line at **1-800-562-6900**. The OIC investigates consumer complaints at no cost. To speed processing of your inquiry or complaint:

- **Call the Hot Line first** to talk to a health insurance expert about your problem and gather any pertinent information. You also can request that a copy of the OIC complaint form be mailed to you. The form is also available on the OIC website at www.insurance.wa.gov
- **Use the form to state your case briefly**, but provide complete information. Be sure to include the name of your insurance carrier, policy number, the name of the agent or adjuster involved, and the name of your employer if the plan is through your employer. Also be sure to sign the medical release on the back of the form.
- **Supply any supporting documentation** you have, including phone notes.
- **State what has been done to resolve** your problem, including whom you talked to and what you were told.



The Insurance Commissioner's compliance analysts will investigate your complaint and keep you advised of what has happened. If the insurer has erred, the compliance analyst will work on your behalf to have the situation corrected. When there is a dispute or a question of fact and you wish to pursue the issue further, legal action may be an option for you. If this applies to your case, the OIC investigator would advise you to consult a lawyer to discuss your options.

The Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine is also a free resource available to you through the OIC. Highly trained volunteer counselors can educate you about your options, assist you with paperwork or other issues, and advocate on your behalf. Call **1-800-397-4422**.

Hotlines, Organizations & Individual Plans

Washington State Office of the Insurance Commissioner

For publications and help with questions and concerns about all types of insurance:
Consumer Advocacy Hotline: (800) 562-6900 or www.insurance.wa.gov

For education and assistance with health insurance and health care access issues, publications, and referral to a local counseling site: **SHIBA HelpLine (800) 397-4422**
www.insurance.wa.gov/consumers/shiba/default.asp

Centers for Medicare and Medicaid Services (CMS)

Medicare Hotline **(800) MEDICARE (1-800-633-4227)**

Local customer service **(206) 615-2345**

Local service for Medicare Managed Care **(206) 615-2351** or www.medicare.gov

Federal Department of Health and Human Services

National Elder Care Locator Service **(800) 677-1116** or www.eldercare.gov

Federal Department of Labor - Employee Benefits Security Administration

Benefit advisors and publication hotline **(866) 275-7022** or www.dol.gov

Federal Social Security Administration

Customer service **(800) 772-1213** or www.ssa.gov

Washington State Health Care Authority

Public Employees Benefit Board (PEBB) www.basichealth.hca.wa.gov

Employee customer service **(800) 700-1555**

Retiree customer service **(800) 200-1004**

Washington State Health Insurance Pool (WSHIP)

An assigned risk pool open to any Washington resident turned down for individual coverage. WSHIP also is the agency that designed and supervised the health screen mandated by the 2000 Legislature. **1-800-877-5187**

www.onlinehealthplan.com/oasys/wship

Companies that offer individual coverage

For more information, contact the insurance company using the toll-free phone number or visit the respective Internet Web site.

Group Health Cooperative of Puget Sound	1-800-358-8815	www.ghc.org
Kitsap Physicians Service	1-800-628-3753	www.kpshealthplans.com
Premiera Blue Cross	1-800-PLAN-ONE (800-752-6663)	www.premiera.com
Lifewise of Washington	1-888-836-6135	www.lifewisewa.com
Regence BlueShield of Washington	1-888-344-8234	www.wa.regence.com
Regence BlueShield of Idaho	1-800-632-2022	www.id.regence.com
Regence BlueShield of Oregon/HMO Oregon	1-800-547-0939	www.or.regence.com



Office of the Insurance Commissioner

P.O. Box 40255

Olympia, Washington 98504-0255

Consumer Advocacy

If you have insurance questions or concerns, call our Consumer Hotline at **1-800-562-6900**. Our Consumer Advocacy staff includes experts in all lines of insurance (auto, homeowner, life, disability and health) and provides assistance and education to consumers.

Consumer Advocacy also has the authority to investigate formal complaints against insurers and agents, and to enforce insurance law on behalf of consumers.

Local help in your community

Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine

For help with health insurance and health care access issues, the SHIBA HelpLine is a service of the Office of the Insurance Commissioner.

The SHIBA HelpLine provides specialized education, assistance and advocacy, including individualized counseling regarding your rights and options, through trained volunteers in your community. Call **1-800-397-4422** to be referred locally for assistance.

All services of the Office of Insurance Commissioner are provided free of charge.

Also see these other publications by the Office of the Insurance Commissioner

- ✓ From the Ground Up: Consumer Guide to Homeowner Insurance
- ✓ In the Driver's Seat: Consumer Guide to Auto insurance
- ✓ Homeowner Complaint Report
- ✓ Automobile Complaint Report
- ✓ Insurance Decoded: Consumer Guide to Insurance Terms
- ✓ Women's Direct Access to Health Care Providers
- ✓ Navigating Health Care Coverage
- ✓ Retirement and Your Health Insurance
- ✓ Medicare, Medigap and You
- ✓ Consumer's Guide to Financing Long-Term Care
- ✓ It's Your Choice: Consumer Guide to Complementary and Alternative Health Care

For a listing of additional publications, visit our Web site:

www.insurance.wa.gov